Physician Related Services

Provided by:

Physicians, Mid-Level Practitioners, Podiatrists, Laboratories, Imaging Facilities, Independent Diagnostic Testing Facilities, and Public Health Clinics

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

December 2003

This publication supersedes all previous Physician, Mid-Level Practitioner, Podiatrist, Laboratory, Imaging Facility, Independent Diagnostic Testing Facility, and Public Health Clinic provider handbooks. Published by the Montana Department of Public Health & Human Services, July 2002.

Updated September 2002, January 2003, June 2003, August 2003, September 2003, December 2003.

My Medicaid Provider ID Number:

MONTANA
Department of Public Health & Human Services

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Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated "In state" will not work outside Montana.

Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Provider Relations

For questions about eligibility, payments, denials, general claims questions, PASSPORT questions, or to request provider manuals, fee schedules:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Claims

Send paper claims to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

ACS Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

Restricted Client Authorization

For authorization for emergency services provided for restricted clients, contact the Surveillance/Utilization Review Section:

(406) 444-4167

All other services must be authorized by the client's designated provider.

PASSPORT Client Help Line

Clients who have general Medicaid questions may call the Client Help Line:

(800) 362-8312

Send written inquiries to:

PASSPORT To Health
P.O. Box 254
Helena, MT 59624-0254

PASSPORT Program Officer

Send inpatient stay documentation to:

PASSPORT Program Officer
DPHHS
Medicaid Services Bureau
P.O. Box 202951
Helena, MT 59620-2951

Provider's Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the G*eneral Information For Providers* manual.

Technical Services Center

Providers who have questions or changes regarding electronic funds transfer should call the number below and ask for the Direct Deposit Manager.

(406) 444-9500

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

CLIA Certification

For questions regarding CLIA certification, call or write:

(406) 444-1451 Phone
(406) 444-3456 Fax

Send written inquiries to:

DPHHS
Quality Assurance Division
Certification Bureau
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953

Lab and X-ray

Public Health Lab assistance:

(800) 821-7284 In state
(406) 444-3444 Out of state and Helena

Send written inquiries to:

DPHHS Public Health Lab
1400 Broadway
P.O. Box 6489
Helena, MT 59620

Lab and X-ray (continued)

Claims for multiple x-rays of same type on same day, send to:

DPHHS
Lab & X-ray Services
Health Policy & Services Division
P.O. Box 202951
Helena, MT 59620

Prior Authorization

The following are some of the Department's prior authorization contractors. Providers are expected to refer to their specific provider manual for prior authorization instructions.

Surveillance/Utilization Review

For prior authorization for certain services (see the *PASSPORT and Prior Authorization* chapter in this manual), contact SURS:

For clients with last names beginning with A - L, call:

(406) 444-3993 Phone

For clients with last names beginning with M - Z, call:

(406) 444-0190

Information may be faxed to:

(406) 444-0778 Fax

Send written inquiries to:
Surveillance/Utilization Review
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953

First Health

For questions regarding prior authorization and continued stay review for selected mental health services.

(800) 770-3084 Phone
(800) 639-8982 Fax
(800) 247-3844 Fax

First Health Services
4300 Cox Road
Glen Allen, VA 23060

Mountain-Pacific Quality Health Foundation

For questions regarding prior authorization for out-of-state hospital services, transplant services, and private duty nursing services, or emergency department reveiws, contact:

Phone:
(800) 262-1545 X150 In state
(406) 443-4020 X150 Out of state and Helena

Fax:
(800) 497-8235 In state
(406) 443-4585 Out of state and Helena

Prior Authorization (Continued)

Send written inquiries to:

Mountain-Pacific Quality
Health Foundation
3404 Cooney Drive
Helena, MT 59602

Key Web Sites

Web Address	Information Available
Virtual Human Services Pavilion (VHSP) vhsp.dphhs.state.mt.us	**Select *Human Services* for the following information:** • **Medicaid:** Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information. • **Senior and Long Term Care:** Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning. • **DPHHS:** Latest news and events, Mental Health Services Plan information, program information, office locations, divisions, resources, legal information, and links to other state and federal web sites. • **Health Policy and Services Division:** Children's Health Insurance Plan (CHIP), Medicaid provider information such as manuals, newsletters, fee schedules, and enrollment information.
Provider Information Website www.mtmedicaid.org or www.dphhs.state.mt.us/hpsd/medicaid/medicaid2	• Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • HIPAA Update • Newsletters • Key contacts • Links to other websites and more
Client Information Website www.dphhs.state.mt.us/hpsd/medicaid/medrecip/medrecip.htm	• Medicaid program information • Client newsletters • Who to call if you have questions • Client Notices & Information
Health Policy and Services Division (Now Child and Adult Health Resources Division) www.dphhs.state.mt.us/hpsd	• **Medicaid:** See list under **Provider Information Website** above, and Client Information is available also • **CHIP**: Information on the Children's Health Insurance Plan • **Public Health:** Disease prevention (immunizations), health and safety, health planning, and laboratory services • **Administration:** CAHRD budgets, staff and program names and phone numbers, program statistics, and systems information. • **News:** Recent developments
Center for Disease Control and Prevention (CDC) web site www.cdc.gov/nip	Immunization and other health information
Parents Lets Unite for Kids (PLUK) www.pluk.org	This web site gives information on PLUK – an organization designed to provide support, training, and assistance to children with disabilities and their parents.
Medicaid Mental Health and Mental Health Services Plan www.dphhs.state.mt.us/about_us/divisions/addictive_mental_disorders/services/public_mental_health_services.htm	Mental Health Services information for Medicaid and MHSP

- The following table (*PA Criteria for Specific Services*) lists services that require PA, who to contact, and specific documentation requirements. For more details on each service listed in the following table, please contact the prior authorization contact listed.
- For a list of prescription drugs that require PA, see the *PA Criteria for Prescription Drugs* table later in this chapter.
- Have all required documentation included in the packet before submitting a request for PA (see the following *PA Criteria for Specific Services* table for documentation requirements).
- Prior authorization criteria forms for most services are available on the Provider Information website (see Key Contacts)
- When PA is granted by the Surveillance/Utilization Review Section, providers will receive notification from both the Quality Assurance Divison and the Claims Processing Unit. The *Prior Authorization Notice* from the Claims Processing Unit will have a PA number. This PA number must be included in field 23 on the CMS-1500 claim form.

PA Criteria for Specific Services

Service	PA Contact	Documentation Requirements

• **All transplant services**
• **Out-of-state hosptial inpatient services**
• **All rehab services**
	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 443-4020 X150 Helena
	(800) 262-1545 X150 In/out-of-state
	Fax:
	(406) 443-4585 Helena
	(800) 497-8235 In/out-of-state
		• Required information includes:
		  • Client's name
		  • Client's Medicaid ID number
		  • State and hospital where client is going
		  • Documentation that supports medical necessity. This varies based on circumstances. Mountain-Pacific Quality Health Foundation will instruct providers on required documentation on a case-by-case basis.

• **Transportation (scheduled ambulance transport, commercial and specialized non-emergency transportation)**
 	
(For emergency ambulance transport services, providers have 60 days following the service to obtain authorization.)
	Mountain-Pacific Quality Health Foundation
	Medicaid Transportation
	P.O. Box 6488
	Helena, MT 59604
	
	Phone:
	(800) 292-7114
	Fax:
	(800) 291-7791
	E-Mail:
	ambulance@mpqhf.org
		• Ambulance providers may call, leave a message, fax, or E-mail requests.
		• Required information includes:
		  • Name of transportation provider
		  • Provider's Medicaid ID Number
		  • Client's name
		  • Client's Medicaid ID number
		  • Point of origin to the point of destination
		  • Date and time of transport
		  • Reason for transport
		  • Level of services to be provided during transport (e.g., BLS, ALS, mileage, oxygen, etc.)
		• Providers must submit the trip report and copy of the charges for review after transport.
		• For commercial or private vehicle transportation, clients call and leave a message, or fax travel requests prior to traveling.

• **Eye prosthesis** • **New technology codes (Category III CPT codes)** • **Other reviews referred by Medicaid program staff**	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-2953 **Phone:** For clients with last names beginning with **A - L**, call: (406) 444-3993 In/out-of-state For clients with last names beginning with **M - Z**, call: (406) 444-0190 In/out-of-state **Fax:** (406) 444-0778	• Documentation that supports medical necessity • Documentation regarding the client's ability to comply with any required after care • Letters of justification from referring physician • Documentation should be provided at least two weeks prior to the procedure date.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Circumcision**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Circumcision requests are reviewed on a case-by-case basis based on medical necessity when one of the following occurs:
		  • Client has scarring of the opening of the foreskin making it non-retractable (pathological phimosis). This is unusual before five years of age. The occurrence of phimosis must be treated with non-surgical methods (i.e., topical steroids) before circumcision is indicated.
		  • Documented recurrent, troublesome episodes of infection beneath the foreskin (balanoposthitis) that does not respond to other non-invasive treatments and/or sufficient hygiene
		  • Urinary obstruction
		  • Urinary tract infections

• **Dispensing and fitting of contact lenses**	Provider Relations
	P.O. Box 4936
	Helena, MT 59604
	
	Phone:
	(406) 442-1837 In/out-of-state
	(800) 624-3958 In state
		• PA required for contact lenses and dispensing fees.
		• Diagnosis must be one of the following:
		  • Keratoconus
		  • Aphakia
		  • Sight cannot be corrected to 20/40 with eyeglasses

• **Prescription Drugs** (For a list of drugs that require PA, refer to the *PA Criteria for Prescription Drugs later in this chapter*.)	Drug Prior Authorization Unit Mountain-Pacific Quality Health Foundation 3404 Cooney Drive Helena, MT 59602 **Phone:** (406) 443-6002 Helena (800) 395-7961 In/out-of-state **Fax:** (406) 443-7014 Helena (800) 294-1350 In/out-of-state	• Refer to the *PA Criteria for Prescription Drugs* table in this chapter for a list of drugs that require PA. • Providers must submit the information requested on the *Request for Drug Prior Authorization Form* to the Drug Prior Authorization Unit. This form is in *Appendix A: Forms*. • The prescriber (physician, pharmacy, etc.) may submit requests by mail, telephone, or FAX to the address shown on the *PA Criteria for Specific Services* table.

• **Maxillofacial/ Cranial Surgery**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Surgical services are only covered when done to restore physical function or to correct physical problems resulting from:
		  • Motor vehicle accidents
		  • Accidental falls
		  • Sports injuries
		  • Congenital birth defects
		• Documentation requirements include a letter from the attending physician documenting:
		  • Client's condition
		  • Proposed treatment
		  • Reason treatment is medically necessary
		• Medicaid does not cover these services for the following:
		  • Improvement of appearance or self-esteem (cosmetic)
		  • Dental implants
		  • Orthodontics

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Blepharoplasty**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Reconstrutive blepharoplasty may be covered for the following:
		  • Correct visual impairment caused by drooping of the eyelids (ptosis)
		  • Repair defects caused by trauma-ablative surgery (ectropion/entropion corneal exposure)
		  • Treat periorbital sequelae of thyroid disease and nerve palsy
		  • Relieve painful symptoms of blepharospasm (uncontrollable blinking).
		• Documentation must include the following:
		  • Surgeon must document indications for surgery
		  • When visual impairment is involved, a reliable source for visual-field charting is recommended
		  • Complete eye evaluation
		  • Pre-operative photographs
		• Medicaid does not cover cosmetic blepharoplasty

• **Botox Myobloc**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• For more details on botox criteria, coverage, and limitations, visit the Provider Information website (see *Key Contacts*)
		• Botox is covered for treating the following:
		Laryngeal spasm
		Blepharospasm
		Hemifacial spasm of the nerve
		Torticollis, unspecified
		Torsion dystonia
		Fragments of dystonia
		Hereditary spastic paraplegia
		Strabismus and other disorders of binocular eye movements
		Other demyelinating diseases of the central nervous system
		Multiple Sclerosis
		Spastic hemiplegia
		Infantile cerebral palsy
		Other specified infantile cerebral palsy
		Achalasia and cardiospasm
		Spasm of muscle
		• Documentation requirements include a letter from the attending physician supporting medical necessity incuding:
		  • Client's condition (diagnosis)
		  • A statement that traditional methods of treatments have been tried and proven unsuccessful
		  • Proposed treatment (dosage and frequency of injections)
		  • Support the clinical evidence of the injections
		  • Specify the sites injected
		• Myobloc is reviewed on a case-by-case basis

• **Excising Excessive Skin and Subcutaneous Tissue**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Required documentation includes the following:
		  • The referring physician and surgeon must document, in the history and physical, the justification for the resection of skin and fat redundancy following massive weight loss.
		  • The duration of symptoms of at least six months and the lack of success of other therapeutic measures
		  • Pre-operative photographs
		• This procedure is contraindicated for, but not limited to, individuals with the following conditions:
		  • Severe cardiovascular disease
		  • Severe coagulation disorders
		  • Pregnancy
		• Medicaid does not cover cosmetic surgery to reshape the normal structure of the body or to enhance a client's appearance.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Rhinoplasty Septorhinoplasty**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• The following do not require PA:
		  • Septoplasty to repair deviated septum and reduce nasal obstruction
		  • Surgical repair of vestibular stenosis to repair collapsed internal valves to treat nasal airway obstruction
		• Medicaid covers rhinoplasty in the following circumstances:
		  • To repair nasal deformity caused by a cleft lip/cleft palate deformity for clients 18 years of age and younger
		  • Following a trauma (e.g. a crushing injury) which displaced nasal structures so that it causes nasal airway obstruction.
		• Documentation requirements include a letter from the attending physician documenting:
		  • Client's condition
		  • Proposed treatment
		  • Reason treatment is medically necessary
		• Not covered
		  • Cosmetic rhinoplasty done alone or in combination with a septoplasty
		  • Septoplasty to treat snoring

• **Temporomandibular Joint (TMJ) Arthroscopy/ Surgery**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Non-surgical treatment for TMJ disorders must be utilized **first** to restore comfort, and improve jaw function to an acceptable level. Non-surgical treatment may include the following in any combination depending on the case:
		  • Fabrication and insertion of an Intra-oral Orthotic
		  • Physical therapy treatments
		  • Adjunctive medication
		  • Stress management
		• Surgical treatment may be considered when both of the following apply:
		  • Other conservative treatments have failed (must be documented), and chronic jaw pain and dysfunction have become disabling. Conservative treatments must be utilized for six months before consideration of surgery.
		  • There are specific, severe structural problems in the jaw joint. These include problems that are caused by birth defects, certain forms of internal derangement caused by misshapen discs, or degenerative joint disease. For surgical consideration, arthrogram results must be submitted for review.
		• Not covered:
		  • Botox injections for the treatment of TMJ is considered experimental.
		  • Orthodontics to alter the bite
		  • Crown and bridge work to balance the bite
		  • Bite (occlusal) adjustments

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Dermabrasion/ Abrasion Chemical peel**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Services covered for the following:
		  • Treating severe, deep acne scarring not responsive to conservative treatment. All conservative treatments must have been attempted and documented for at least six months before medical necessity is determined.
		  • The removal of pre-cancerous skin growths (keratoses)
		• Documentation requirements include a letter from the attending physician documenting:
		  • Client's condition
		  • Proposed treatment
		  • Reason treatment is medically necessary
		  • Pre-operative photographs

• **Positron Emission Tomography (PET) Scans**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• PET scans are covered for the following clinical conditions: (For more details on each condition and required documentation, contact the SURS unit.)
		  • Solitary pulmonary nodules (SPNs) - characterization
		  • Lung cancer (non small cell) - Diagnosis, staging, restaging
		  • Esophageal cancer - Diagnosis, staging, restaging
		  • Colorectal cancer - Diagnosis, staging, restaging
		  • Lymphoma - Diagnosis, staging, restaging
		  • Melanoma - Diagnosis, staging, restaging. Not covered for evaluating regional nodes
		  • Breast cancer - As an adjunct to standard imaging modalities for staging clients with distant metastasis or restaging clients with locoregional recurrence or metastasis; as an adjunct to standard imaging modalities for monitoring tumor response to treatment for women with locally and metastatic breast cancer when a change in therapy is anticipated
		  • Head and neck cancers (excluding CNS and thyroid) - Diagnosis, staging, restaging
		  • Myocardial Viability - Primary or initial diagnosis, or following an inconclusive SPECT prior to revascularization. SPECT may not be used following an inconclusive PET scan.
		  • Refractory Seizures - Covered for pre-surgical evaluation only.
		  • Perfusion of the heart using Rubidium 82 tracer (Not DFG-PET) - Covered for noninvasive imaging of the perfusion of the heart.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Reduction Mammoplasty**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT
	59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Both the Referring physician and the surgeon must submit documentation.
		• Back pain must have been documented and present for at least six months, and causes other than weight of breasts must have been excluded.
		• **Indications for female client:**
		• Contraindicated for pregnant women and lactating mothers. A client must wait six months after the cessation of breast feeding before requesting this procedure.
		• Female client 16 years or older with a body weight less than 1.2 times the ideal weight.
		• There must be severe, documented secondary effects of large breasts, unresponsive to standard medical therapy administered over at least a six month period. This must include at least two of the following conditions:
		  • Upper back, neck, shoulder pain that has been unresponsive to at least six months of documented and supervised physical therapy and strengthening exercises
		  • Paresthesia radiating into the arms. If parathesia is present, a nerve conduction study must be submitted.
		  • Chronic intertrigo (a superficial dermatitis) unresponsive to conservative measures such as absorbent material or topical antibiotic therapy. Document extent and duration of dermatological conditions requiring antimicrobial therapy.
		  • Significant shoulder grooving unresponsive to conservative management with proper use of appropriate foundation garments which spread the tension of the support and lift function evenly over the shoulder, neck and upper back.
		Documentation in the client's record must indicate and support the following:
		• History of the client's symptoms related to large, pendulous breasts.
		• The duration of the symptoms of at least six months and the lack of success of other therapeutic measures (e.g., documented weight loss programs with six months of food and calorie intake diary, medications for back/neck pain, etc.).
		• Guidelines for the anticipated weight of breast tissue removed from each breast related to the client's height (which must be documented):
		Height — **Weight of tissue per breast**
		less than 5 feet — 250 grams
		5 feet to 5 feet, 2 inches — 350 grams
		5 feet, 2 inches to 5 feet, 4 inches — 450 grams
		greater than 5 feet, 4 inches — 500 grams
		• Pre-operative photographs of the pectoral girdle showing changes related to macromastia.
		• Medication use history. Breast enlargements may be caused by various medications (e.g., sironolactone, cimetidine) or illicit drug abuse (e.g., marijuana, heroin, steroids). Although rare in women, drug effects should be considered as causes of breast enlargement prior to surgical treatment since the problem may recur after the surgery if the drugs are continued. Increased prolactin levels can cause breast enlargement (rare). Liver disease, adrenal or pituitary tumors may also cause breast enlargement and should also be considered prior to surgery.
		• **Indications for male client:**
		• If the condition persists, a client may be considered a good candidate for surgery. Clients who are alcoholic, illicit drug abusers (e.g., steroids, heroin, marijuana) or overweight are not good candidates for the reduction procedure until they attempt to correct their medical problem first.
		• Documentation required: length of time gynecomastia has been present, height, weight, and age of the client, pre-operative photographs

PA Criteria for Prescription Drugs

Drug	Criteria
Non-steroidal Anti-Inflammatory Drugs PA required for all single-source NSAIDS: Ponstel Mobic Naprelan	Trial and failure with at least <u>two</u> multiple-source products must be documented.
Celebrex (celecoxib) Vioxx (rofecoxib) Bextra (valdecoxib)	No history of aspirin sensitivity or allergy to aspirin or other NSAID, and/or aspirin triad, and at least one of the following: • History of previous GI bleeding within the last 5 years • Current or recurrent gastric ulceration • History of NSAID-induced gastropathy • Currently treated for GERD For clients 65 and older, no concomitant aspirin use. Vioxx 50mg is not recommended for chronic use. Medicaid does not cover Vioxx at this dose for extended periods.

Disease-modifying anti-rheumatic drugs (DMARD)
Arava (leflunomide)
Enbrel (etanercept)
Humira (adalimumab)
Kineret (anakinra)
Remicade (infliximab)
	• Diagnosis of rheumatoid arthritis
	• Rheumatology consult with date and copy of consult included
	• Failure with or contraindication to methotrexate alone or in combination with sulfasalazine, hydroxychloroquine or Arava, in which case Enbrel, Remicade, or Kineret may be approved either alone or in combination with Arava.
	• Kineret may be used alone or in combination with DMARD's other than tumor necrosis factor (TNF) blocking agents (i.e. Enbrel)
	  • Enbrel or Remicade whether alone or in combination with methotrexate or Arava may be approved for first-line treatment in patients with moderately to severely active rheumatoid arthritis as evidenced by:
	  • > 10 swollen joints
	  • ≥ 12 tender joints
	  • Elevated serum rheumatoid factor levels or erosions on baseline x-rays

Remicade (infliximab)	Diagnosis of: • Moderately to severely active Crohn's disease for patients with an inadequate response to conventional therapy • Fistulizing Crohn's disease
Ambien (zolpidem) Sonata (zaleplon) Quantity limited to 15 tablets per month.	Trial and failure with at least <u>two</u> multi-source prescription sleep-inducing drugs.
Oxycodone HCL Controlled-Release (OxyContin)	• Diagnosis of oncologic pain • Prior authorization is required for all dosing above twice a day and above 320 mg per day.

Using Modifiers

- Review the guidelines for using modifiers in the most current CPT-4, HCPCS Level II, or other helpful resources.
- Always read the complete description for each modifier; some modifiers are described in the CPT-4 manual while others are in the HCPCS Level II book.
- The Medicaid claims processing system recognizes only two pricing modifiers and one informational modifier per claim line. Providers are asked to place any modifiers that affect pricing in the first two modifier fields.
- When billing with modifier 50 for bilateral services, put all information on one line with one unit. For example, a bilateral carpal tunnel surgery would be billed like this:

	24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	08	23	02	08	23	02	22	0	64721	50	1	800 00	1				

- Check the fee schedule to see if Medicaid allows the use of the following modifiers for a particular code: bilateral (50), multiple procedures (51), co-surgery (62), assistant at surgery (80, 81, 82, AS), and team surgery (66).
- Always bill your main surgical procedure code on line 1 of the claim with one unit only. All other subsequent procedures should be billed with the number of units done for each code per line. For instance, if the main procedure code is 11600, one unit, and the subsequent procedure code is 11601, two units, bill as follows:

	24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	03	05	02	03	05	02	11	0	11600		1	115 00	1				
2	03	05	02	03	05	02	11	0	11601	51	1	140 00	2				

Do not separate out subsequent procedure codes (e.g., code 11601 51 twice) on separate lines. This will cause exact duplicate line denials. Subsequent procedure modifiers should be used when appropriate (for example: modifiers 51 or 59), except when billing add-on codes and modifier 51 exempt codes.

Billing Tips for Specific Provider Types

Mid-level practitioner billing

Mid-level practitioners must bill under their own Medicaid ID number rather than under a physician number.

Physician billing

- Medicaid-enrolled providers may bill for locum tenens services using modifier Q6.
- Durable medical equipment (DME) providers must bill prosthetic and orthotic devices under their DME provider number. Physicians may bill

only specific DME supplies and must check the fee schedule for appropriate codes.

Podiatrist billing

Podiatrists must use appropriate codes and modifiers from their specific fee schedule.

Independent diagnostic testing facilities

IDTF providers must use appropriate fee schedules, codes, and modifiers for their provider type.

Independent labs

- The provider's current CLIA certification number must be on file with Provider Relations or all lab claims will be denied. See *Key Contacts* for CLIA certification information.
- This requirement also applies to public health labs. Questions regarding public health labs may be directed to the Public Health Lab Assistance hotline (see *Key Contacts)*.

Imaging

- Occasionally multiple radiology services are performed on the same day for the same client by the same or different providers. When circumstances warrant it, repeat modifiers may be used as demonstrated in the following example. Repeat modifiers are specific modifiers used to indicate that a service is a repeat rather than a duplicate.

24. A						B	C	D		E	F	G	H	I	J	K
DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
1 03	05	02	03	05	02	11	0	71020		1	34 00	1				
2 03	05	02	03	05	02	11	0	71020	77	1	34 00	1				

- If a claim is denied as a duplicate, send copies of the radiology report, the denial statement, and the claim to the appropriate Department program officer (see *Key Contacts, Lab and X-ray*) for review.
- For bilateral x-rays, bill on separate lines, one line with modifier RT and one line with modifier LT. The exception would be codes that are described as bilateral in their code description. These are to be billed on one line with one unit.
- Imaging providers must take particular care in the use of modifiers. The TC modifier is used when only the technical portion of the service is provided. The provider who interprets the results uses modifier 26. When both technical and professional services are performed by the same provider, no modifier is required.

Billing Tips for Specific Services

Abortions

A completed *Medicaid Recipient/Physician Abortion Certification* (MA-37) form must be attached to every abortion claim or payment will be denied (see *Appendix A: Forms*). This is the only form Medicaid accepts for abortions.

Anesthesia

- Use appropriate CPT-4 anesthesia codes.
- Do not use surgery codes with an anesthesia modifier.
- For services where codes or definitions differ between the CPT-4 and the *American Society of Anesthesiologists' Relative Value Guide*, Medicaid adopts the CPT-4 version.
- Include the total number of minutes in field 24g (*Days or Units)* on the CMS-1500 claim form. Medicaid will convert the number of minutes to the number of time units. Do not include the base units on the CMS-1500 as the claims processing system determines the number of base units (see the *Completing a Claim* chapter in this manual).

Bundled services

Certain services with CPT-4 codes (eg., telephone advice, some pulse oximetry services) are covered by Medicaid but have a fee of zero. This means that the service is typically "bundled" with an office visit or other service. Since the bundled service is covered by Medicaid, providers may not bill the client separately for it.

Cosmetic services

Include the prior authorization number in field 23 (*Prior Authorization Number*) on the CMS-1500 claim form (see the *Completing a Claim* chapter in this manual).

EPSDT Well Child Screens

- Bill for a complete screen using the appropriate evaluation and management (E&M) code for preventive medicine services.
- When billing for partial screens, use the appropriate preventive medicine code with modifier 52 (reduced services).
- See also the EPSDT chapter in this manual.
- For EPSDT overrides on limits and cost sharing, see the *Completing a Claim* chapter in this manual.

Family planning services

Contraceptive supplies and reproductive health items provided free to family planning clinics cannot be billed to Medicaid. When these supplies are not free to the clinic, providers associated with a family planning clinic can bill Medicaid for the following items:

Item	Code
Diaphragm	A4266
Male condoms	A4267
Female condoms	A4268
Spermicide	A4269
Oral contraceptives	S4993

For family planning overrides on cost sharing, see the *Completing a Claim* chapter in this manual.

Immunizations

- Use code 90471 with modifier SL to bill for the administration of vaccines under the Vaccines for Children (VFC) program. Use 90472-SL for subsequent VFC administrations.
- There must be a VFC covered code for each unit of service billed with code 90471-SL and 90472-SL. For a list of VFC covered vaccines, contact the Department's immunization program at (406) 444-5580.
- No more than four diagnosis codes are necessary.
- Bill each VFC code with $0.00 charges.

For example, a provider administers three vaccines: MMR, pneumococcal conjugate, and DTaP.

24. A						B	C	D		E	F		G	H	I	J	K
DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
1 12	12	03	12	12	03	11	0	90471	SL	1	10	00	1				
2 12	12	03	12	12	03	11	0	90472	SL	1	20	00	2				
3 12	12	03	12	12	03	11	0	90707		1	0	00	1				
4 12	12	03	12	12	03	11	0	90669		1	0	00	1				
5 12	12	03	12	12	03	11	0	90700		1	0	00	1				

Obstetrical services

If the provider's care includes prenatal (antepartum) and/or postnatal (postpartum) care in addition to the delivery, the appropriate global OB code must be billed. Antepartum care includes all visits until delivery, and there are different codes for specified numbers of visits. There are also different codes for antepartum and postpartum care when only one or the other is provided. Please review your CPT coding book carefully.

Reference lab billing

Under federal regulations, all lab services must be billed to Medicaid by the lab that performed the service. Modifier 90, used to indicate reference lab services, is not covered by Medicaid.

Sterilization

- For elective sterilizations, a completed *Informed Consent to Sterilization* (MA-38) form must be attached to the claim for each provider involved or payment will be denied. This form must be legible, complete, and accurate, and revisions are not accepted. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician.
- For medically necessary sterilizations (including hysterectomies), one of the following must be attached to the claim, or payment will be denied:
    - A completed *Medicaid Hysterectomy Acknowledgement* form (MA- 39) for each provider submitting a claim. See *Appendix A Forms* for the form and instructions. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. The client must sign and date this form at least 30 days prior to the procedure (see 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations).
    - For clients who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
        - The individual was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
        - The reason for the hysterectomy was a life-threatening emergency.
        - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

For more information on sterilizations, see the *Covered Services* chapter in this manual.

Surgical services

- Medicaid does not provide additional payment for the "operating room" in a physician's office. Medicaid pays facility expenses only to licensed hospitals and ambulatory surgical centers.
- ***Reporting surgical services:*** Certain surgical procedures must not be reported together, such as:
    - Procedures that are mutually exclusive based on the CPT-4 code description or standard medical practice.

- When both comprehensive and component procedures are performed, only the comprehensive procedure must be billed.
- When the CPT-4 manual describes several procedures of increasing complexity, only the code describing the most extensive procedure performed must be reported.

Medicaid edits for some surgical services using Medicare's Correct Coding Initiative (CCI) edits and performs post-payment review on others. See *Coding Resources* earlier in this chapter for more information on CCI.

- ***Assistant at surgery***
  - When billing for an assistant at surgery, refer to the current Medicaid Department fee schedule to see if an assist is allowed for that procedure.
  - If an assistant at surgery does not use the appropriate modifier, then either the assistant's claim or the surgeon's claim (whichever is received later) will be denied as a duplicate service.
  - Physicians must bill assistant at surgery services using the appropriate surgical procedure code and modifier 80, 81, or 82.
  - Mid-level practitioners must bill assistant at surgery services under their own provider number using the appropriate surgical procedure code and modifier AS, 80, 81, or 82.
- ***Global surgery periods:*** Global surgery periods are time spans assigned to surgery codes. During these time spans, services related to the surgery may **not** be billed. Group practice members that are of the same specialty must bill Medicaid as if a single practitioner provided all related follow-up services for a client. For example, Dr. Armstrong performs orthopedic surgery on a client. The client comes in for a follow-up exam, and Dr. Armstrong is on vacation. Dr. Armstrong's partner, Dr. Black, performs the follow-up. Dr. Black cannot bill this service to Medicaid, because the service was covered in the global period when Dr. Armstrong billed for the surgery.
  - For major surgeries, this span is 90 days and includes the day prior to the surgery and the following services: post-operative surgery related care and pain management and surgically-related supplies and miscellaneous services.
  - For minor surgeries and endoscopies, the spans are either one day or ten days. They include any surgically-related follow-up care and supplies on the day of surgery, and for a 10-day period after the surgery.
  - For a list of global surgery periods by procedure code, please see the current Department fee schedule for your provider type.
  - If the CPT-4 manual lists a procedure as including the surgical procedure only (i.e., a "starred" procedure) but Medicaid lists the code with a

global period, the Medicaid global period applies. Almost all Medicaid fees are based on Medicare relative value units (RVUs), and the Medicare relative value units were set using global periods even for starred procedures. Montana Medicaid has accepted these RVUs as the basis for its fee schedule.

- In some cases, a physician (or the physician's partner of the same specialty in the same group practice) provides care within a global period that is unrelated to the surgical procedure. In these circumstances, the unrelated service must be billed with the appropriate modifier to indicate it was not related to the surgery.

Telemedicine services

- When performing a telemedicine consult, use the appropriate CPT-4 evaluation and management (E&M) consult code.
- The place of service is the location of the provider providing the telemedicine service.
- Medicaid does not pay for network use or other infrastructure charges.

Transplants

Include the prior authorization number in field 23 (*Prior Authorization Number*) on the CMS-1500 claim form (see the *Completing a Claim* chapter in this manual). All providers must have their own prior authorization number for the services. For details on obtaining prior authorization, see the *PASSPORT and Prior Authorization* chapter in this manual.

Weight reduction

Providers who counsel and monitor clients on weight reduction programs must bill Medicaid using appropriate evaluation and management (E&M) codes.

Submitting a Claim

Paper claims

Unless otherwise stated, all paper claims must be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

Electronic claims

Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- Accelerated Claims Entry Software (ACE$)
- A claims clearinghouse

- By writing your own software using NSF 3 Montana Medicaid specifications

For more information on electronic claims submission, call the Provider Relations number (see *Key Contacts*), and follow the instructions for reaching Electronic Data Interchange (EDI). The information on electronic claims submission will change with the implementation of the electronic transaction standards under the Health Insurance Portability and Accountability Act (HIPAA). Providers will be notified of changes in the *Montana Medicaid Claim Jumper* newsletter.

Claim Inquiries

Contact Provider Relations for questions regarding client eligibility, payments, denials, general claim questions, or to request billing instructions, manuals, or fee schedules (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A*. Complete the top portion of the form with the provider's name and address. If you are including a copy of the claim, complete side A; if a copy of the claim is not included, complete side B.

Provider Relations will respond to the inquiry within 7 to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.

Common Billing Errors (continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client: • View the client's eligibility information at each visit. Medicaid eligibility may change monthly. • Verify client eligibility by using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.
Duplicate claim	• Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim form (see *Remittance Advices and Adjustments* in this manual). • Please allow 45 days for the Medicare/Medicaid Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.
Procedure requires PASSPORT provider approval – No PASSPORT approval number on claim	A PASSPORT provider approval number must be on the claim form when such approval is required. See the *PASSPORT and Prior Authorization* chapter in this manual.
Prior authorization number is missing	• Prior authorization (PA) is required for certain services, and the PA number must be on the claim form (see the *PASSPORT and Prior Authorization* chapter in this manual). • Mental Health Services Plan (MHSP) claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization. See the *Mental Health Services Plan* manual.
TPL on file and no credit amount on claim	• If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See *Coordination of Benefits* in this manual. • If the client's TPL coverage has changed, providers must notify the TPL unit (see *Key Contacts*) before submitting a claim.
Claim past 365-day filing limit	• The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in *Key Contacts*.

Common Billing Errors (continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Missing Medicare EOMB	All Medicare crossover claims on CMS-1500 forms must have an Explanation of Medicare Benefits (EOMB) attached, and be billed to Medicaid on paper.
Provider is not eligible during dates of services, or provider number terminated	• Out-of-state providers must update enrollment early to avoid denials. If enrollment has lapsed, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.
Type of service/procedure is not allowed for provider type	• Provider is not allowed to perform the service, or type of service is invalid. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual. • Check the Medicaid fee schedule to verify the procedure code is valid for your provider type.

Other Programs

These billing procedures also apply to the Mental Health Services Plan (MHSP). These billing procedures do not apply to the Children's Health Insurance Plan (CHIP). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

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